MDR Tracking Number: M5-04-0482-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-15-03

The IRO reviewed therapeutic procedures, neuromuscular, re-education, office visits, manual traction, modalities (vasopneumatic, electrical stimulation, hot or cold packs) and DME rendered from 12-06-02 through 12-20-02 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity for therapeutic procedures, neuromuscular, re-education, office visits, manual traction, modalities (vasopneumatic, electrical stimulation, hot or cold packs) and DME. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 12-19-03, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
11/08/02 11/11/02 11/13/02	99213 (3 dates of service)	$150.00	0.00	F	$48.00	MFG E&M GR (IV)(C)(2),	Requestor submitted information stating that a surgery was never performed on this patient. Soap notes do confirm delivery of service. Therefore recommended reimbursement is $144.00 ($48.00 for 3 dates of service)
TOTAL		$150.00					The requestor is entitled to reimbursement of **$** 144.00

This Decision is hereby issued this 9th day of March 2004.

Georgina Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 11-08-02 through 12-09-02 in this dispute.

This Order is hereby issued this 9th day of March 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

December 22, 2003

NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter

RE: MDR Tracking #: M5-04-0482-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a 26 year-old male who sustained a work related injury on ___. The patient reported that while at work he injured his back when he was lifting a heavy object. An MRI dated 11/4/02 showed disc herniation at L5-S1 of 3mm with a 11mm base. An EMG dated 11/5/02 indicated bilateral L5 radiculopathy.

The diagnoses for this patient have included lumbar vertebral subluxation, lumbar strain/sprain, I.V.D. disorder with myelopathy and radiculitis. Treatment for this patient has included chiropractic manipulations, therapy that included active and passive therapy, vasopneumatic, TEI, manual traction, NMRE, educational training and oral medications. On 11/19/02 the patient was evaluated by pain management. The patient has also undergone a lumbar epidural steroid injection on 12/12/02.

Requested Services

Therapeutic procedures, neuromuscular reeducation, office visit/outpatient, traction manual, modalities (vaso, electric stimulation, hot/cold pack therapy), and DME from 12/6/02 through 12/20/02.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a 26 year-old male who sustained a work related injury to his back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient have included lumbar vertebral subluxation, lumbar strain/sprain, I.V.D. disorder with myelopathy and radiculitis. The ___ chiropractor reviewer further noted that the treatment for this patient has included chiropractic manipulations, therapy that included active and passive therapy, vasopneumatic, TEI, manual traction, NMRE, educational training and oral medications and epidural steroid injections. The ___ chiropractor reviewer indicated that the patient sustained a sprain/strain injury with some disc involvement. The ___ chiropractor reviewer explained that this patient's treatment was consistent with standard guidelines and his pain was improving. The ___ chiropractor reviewer noted that evaluations from pain management and an orthopedic surgeon indicated that further conservative care was appropriate. The ___ chiropractor reviewer explained that during the two weeks in question the patient's pain worsened only once after an epidural steroid injection. The ___ chiropractor reviewer also explained that afterwards, the patient's pain decreased. The ___ chiropractor reviewer further explained that reports from all the physicians involved in this patient's care were consistent. Therefore, the ___ chiropractor consultant concluded that the therapeutic procedures, neuromuscular reeducation, office visit/outpatient, traction manual, modalities (vaso, electric stimulation, hot/cold pack therapy), and DME from 12/6/02 through 12/20/02 were medically necessary to treat this patient's condition.

Sincerely,